INLAND COUNTIES EMERGENCY MEDICAL AGENCY
Serving San Bernardino, Inyo, and Mono Counties
1425 South "D" Street
SAN BERNARDINO, CA 92415-0060
909-388-5823 FAX: 909-388-5825

SPECIALTY AND OPTIONAL SCOPE PROGRAM APPROVAL APPLICATION

PROVIDER INFORMATION

Name: _____

Address: _____
Number & Street City State Zip

ADMINISTRATION

Name of proposed Medical Director: _____

Phone: _____ Email: _____

Name of proposed Coordinator & Title: _____

Phone: _____ Email: _____

PROGRAM DETAILS (*Reference Protocol #6060, Procedure Section*)

SUBMIT THE FOLLOWING FOR PROGRAM REVIEW:

- ☐ Completed original application.
- ☐ Copy of the proposed program, which shall include:
  - A statement demonstrating a need for the program.
  - A description when the program will operate (special events, 24/7) and how implemented.
  - A description of how the program will interface with the EMS system and 9-1-1.
  - A description of the training and list of employees participating in the program. (*If there are changes, ICEMA must be notified within 10 days.*)
  - Does program require deviations from the Standard Drug and Equipment List? Provide detailed list and how equipment and drugs will be transported and stored.
  - Overview of the quality improvement plan and process for reporting any deviations.

Additional information may be requested after program is reviewed.

Completed by: _____
(*Please print*)

Signature: _____ Date: _____

ICEMA Use Only

Date Rcvd:_____ All requirements verified:_____ Approved by:_____ Date:_____